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Unrecognised Pillars Of Public Health: The Struggles Of Asha Workers In India

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ABSTRACT

India's burgeoning population can afford an unorganised work force, however, whether the State can accord them formal status of 'Employee' is uncertain. The Accredited Social Health Activists (ASHAs) play a pivotal role in India's rural healthcare delivery, delivering maternal and child healthcare, immunisation, and prevention of diseases. Although they play a critical role, they are defined as 'volunteers' perpetuating economic disparities based upon gender and excluded from formal employment privileges like fixed pay, pensions, and social security. This paper critically analyses their tenuous legal position under Indian labour laws and constitutional provisions, placing their work in the wider care and gig economies. Using International human rights instruments, such as the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the paper shows how India's handling of ASHAs negates core labour rights. The article also contrasts India's model with international best practices, examining structured community health worker (CHW) programs in Brazil, South Africa, Ethiopia, Rwanda, China, and Russia. In contrast to ASHAs, CHWs in these nations are formally trained, paid a fixed salary, and provided social security, ensuring financial security and professional status. India's system based on incentives keeps ASHAs financially vulnerable and open to exploitation, further worsened by the COVID-19 pandemic when they were assigned frontline work without proper compensation or protection. By suggesting harmonisation of India's policies with global standards and acknowledging ASHAs as a part of the public health infrastructure, the government can facilitate equity, dignity, and sustainability of healthcare delivery. Enforcing ASHAs' rights will not only strengthen the workers but also the overall efficacy of India's public health system. While acknowledging, defining, and sufficiently paying CHWs is not all about social justice, it's an inevitable initiative to accomplish the universal health cover

KEYWORDS: ASHAs, Labour Rights, Care Economy, Gender Equity, Social Security.

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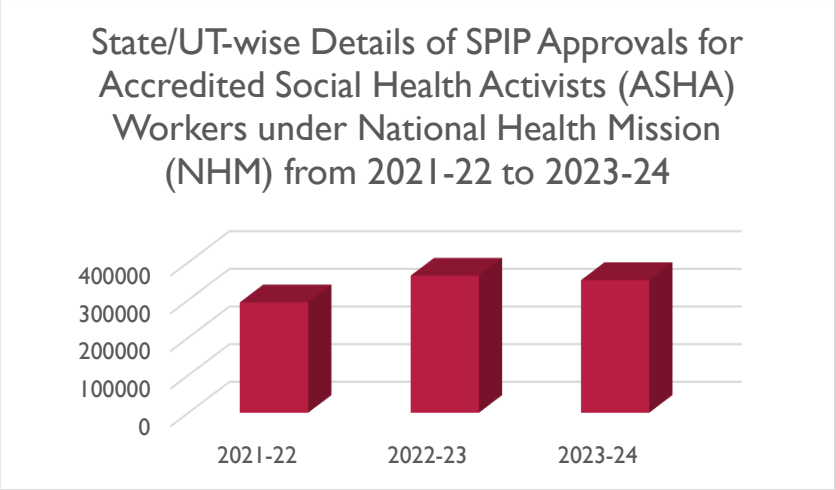
INTRODUCTION

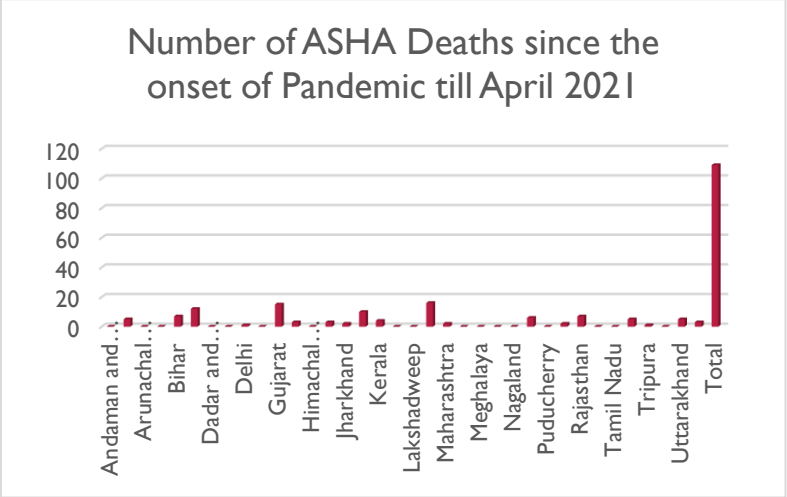
One of the persistent challenges the Republic of India has regularly faced, since its independence, is about provision and accessibility to primary health services of its ever-increasing population. Evident reality being the concentration of health services in cities and concomitantly rural India lagging enormously. Realising the perceptible gap, it was with much hope and ambition the National Rural Health Mission (NHRM) was launched in 2005. The foremost objective of NHRM was to bridge the gap between urban area primary health services as compared to the rural areas. Alleviation of availability of health services to rural areas was a humongous task, considering the substantial majority population residing in the rural areas. For achieving the objectives of NHRM the first investment was expected to be towards Human Resource. This required the involvement of a good number of skilled and semi skilled women from each rural area as the first responder for the needs of primary health. However, the data of funds allocated and spent by respective States towards implementation of NHRM objectives is mostly with respect to the compensation to the ASHA workers which is way less than prevalent minimum wages according to the Code on Wages, 2019.



(Source: Rajya Sabha Session - 267 Unstarred Question No. 1388 Answered on, 11th March 2025. Data Figures are Rupees in Lakh. The given data is as per the available Financial Management Reports (FMRs) reported by the States/UTs for State Programme Implementation Plan.)[1]

The ideation of workability was commendable and it did change the graph of accessibility to health aid at the farthest corners of the country. However, without challenging the government data on accessibility to health services, the attempts of its sustainability have not been looked upon by successive governments. India's Accredited Social Health Activists (ASHAs) form the backbone of the public healthcare system, providing essential services at the grassroots level. They are the backbone for many reasons, foremost of it being that the women trained and certified as the first responders to child and women health are residents of the same locality. The ASHAs are trained at gram panchayat or block level. They comprise predominantly and in bulk women, who were specifically trained for the purposes of women and child health sensitisation. The initial applications were driven by the young unemployed rural women workforce of India. The support of paltry extra income coming to the small rural household made the government's graphs better. Despite their integral role, ASHAs face systemic neglect in the form of informal employment status, unorganised labour status, inadequate remuneration, and exclusion from social security. This paper, inter alia, explores the challenges faced by ASHA workers, their demands for recognition, and the broader implications of their struggle for equitable labour rights. Currently, the enrolment of ASHA workers has reached its saturation point. The question now is whether the government has any plans to continue providing health services through them. Or, will this system decline and fade away due to the lack of a sustainable plan for upskilling and employment benefits? This paper attempts to raise specific labour rights related problems of ASHA workers. The care economy, encompassing paid and unpaid caregiving, underpins societal well-being but remains undervalued and predominantly female-driven. The gig economy, characterised by flexible, task-based work, often reflects similar vulnerabilities, such as lack of social security and income instability. ASHAs, operating at the intersection of these economies, embody the systemic neglect of care work within labour frameworks.[2]

The encouraging factors of spreading the reach of primary health seems unsustainable in worrying government data about the death of ASHA workers since the onset of pandemic from 2020 till April, 2021.



(Source: Answers Data of Rajya Sabha Questions for Session 254)[3]

The aforesaid data adversely affects the working conditions of an already dwindling workforce of primary health responders of India due to the general apathy towards the wellbeing of the ASHA workers' health itself.

A thorough review by the World Health Organisation ("WHO") looks at the widespread gender imbalances within the global health workforce. In spite of women making up the majority of the health workforce, they remain underrepresented as leaders and are frequently remunerated at lower levels than their male counterparts. The report highlights various contributing factors, among them occupational segregation, gender biases, and the unequal share of unpaid care work held by women. It emphasises the necessity for transformational policies that support gender equality, including establishing equitable pay systems, opening opportunities for women to move into leadership roles, and challenging entrenched biases in healthcare facilities. The WHO urges joint action by policymakers, healthcare institutions, and communities to break down barriers and create an inclusive and equitable health workforce.[4]

This paper hypothesises that labour laws protection to the vital services providers like ASHA will be a leap in the direction of boosting the primary health services to the vulnerable class of our burgeoning population. However, their classification as 'volunteers' denies them formal recognition and labour protections. This systemic exclusion reflects deeper issues at the intersection of the care and gig economies, where economic invisibility and precarious working conditions prevail.

This paper analyses the status of ASHAs under Indian labour laws, the jurisprudence and constitutional philosophy surrounding labour rights, and the challenges they face. It highlights the urgent need for a policy overhaul to ensure equity and justice for ASHA workers, aligning with constitutional principles and labour jurisprudence.

JURISPRUDENTIAL PERSPECTIVES

Assuming that the State is more concerned with public health than widening the ambit of protection of Code on Wages, 2019 towards more workers of our country, is it possible to admit that quick medical aid can reach the remotest location of our country without the ASHA worker? Is it possible that well trained, certified and skilled nurses will be posted to remote villages without a hospital infrastructure to provide health services door to door? The answer will be an emphatic No. The answer in negative also means that serious cases can always be dealt with, in the hospital better. Agreed, but can a first responder team not be recognised who are readily available on doorstep at least to help and inform the right course of action in case of medical emergency arising in the remote area? Is public health and the persons associated with it not discharging a duty-based work which is perennial in nature? If it is perennial in nature can the worker performing such duties are not entitled to regular employment and protected by Code on Wages, 2019, as amended up to date?

From a jurisprudential perspective, the treatment of ASHA workers, particularly in terms of their classification as volunteers and the absence of formal labour protections, raises critical issues related to the fundamental principles of justice, equality, and human dignity. The principles of justice, as articulated in natural law and social contract theories, argue that every individual has the inherent right to be treated fairly and equitably, regardless of gender or socio-economic status. The fact that ASHAs, who perform vital health-related services, are denied minimum wages, fixed salaries, social security benefits, and other formal labour protections reflects a breach of the social contract between the state and its citizens. The discrimination is more worrying due to the fact that the bulk ASHA workers are women. Women who are already fighting a continuous battle for equal pay throughout the globe. This treatment violates the basic tenets of distributive justice, which calls for fair distribution of benefits and burdens in society, particularly for those whose work directly contributes to vital aspects of public health.

Additionally, the concept of equality as the foundational principle of justice, as articulated by thinkers such as John Rawls, emphasises the 'difference principle', which posits that social and economic inequalities are only justifiable if they benefit the least advantaged members of society. If we seek the question that ASHAS compared to organised sector workmen or as compared to regularised or directly recruited contractual paramedics, which category of labour are least advantaged? The inevitable answer will be the ASHAs. Thus, in Rawlsian theory the inequality if permitted must be for the benefit of ASHAs and not any other class of labour in the same working field. The current system of task-based incentives, that also in primary health, and exclusion from social protections perpetuates inequality rather than rectifying it. By failing to provide these workers with equitable compensation and formal recognition, the state violates the principle of fairness, which requires that social arrangements benefit the most vulnerable and marginalised members of society. ASHAs, primarily women, find themselves at the intersection of both economic exploitation and gender-based discrimination, further reinforcing their social and economic disadvantage.

This perspective of feminist jurisprudence also provides depth into the treatment of ASHA workers. Feminist legal scholars have long argued against the systemic undervaluing of women's labour, especially in the realm of care work, which is oftentimes regarded as 'invisible' or 'natural'.[5] This reflects the broader societal tendency to overlook and undercompensate women's contributions to the health of women and children, which latently contributes to a healthy and sustainable economy, particularly when those contributions occur within the private sphere of caregiving. A classification of group to circumvent the existing law morally unjust, and in law, technically invalid. The feminist jurisprudence considers it as deliberate undervaluation for the purpose of propagating gendered discriminatory practices. Needless to say, that it is also gendered division or labour plainly due to the fact that most of the ASHA workers are women. Revaluation of the work carried out by ASHAs becomes imperative due to these underlying realities.

Further, law in action that attempts towards equality without gender bias or in this context abandoning government's economic interest bias is always appreciated. The making of the laws; the unmaking of the laws through governmental apathy; and finally, inherent gender-based discrimination towards women has always posed realistic challenges. Recorded history tells us that short term needs-based solutions to problems like health, employment opportunities, labour right protections have always hampered the interest of the State in long run. A formal recognition of their work and extending protection to their labour rights is always going to benefit the State and its developmental goals.

Although, every denial of right to equality before law, ultimately results in degradation of legal status and denies the statutory livelihood opportunities is deplorable, but in the case of ASHAs it is alarming because of the essential and perennial work they are executing at the community level.[6] In this context when we look back at the judicial decisions of our Supreme Court in Maneka Gandhi v Union of India[7] and Bandhua Mukti Morcha v Union of India[8] we are left wondering with the question that the aspects of justice, both economic and social, are available only through approaching the Courts or is it a duty of the State as well? Legal recognition of the ASHA workers by the State is the necessity for community level health services, so that their rights can be protected under current labour law regime.

INDIAN LABOUR JURISPRUDENCE

ASHA Workers: Bridging the Gap in Public Health

The enormity of rural areas spread throughout the territory of India even in twenty first century is more than fifty percent of the whole. Rural areas of India are still agrarian and pastoral. Under the circumstances the general female population of rural India is vulnerable class as they are victims of double discrimination. The past governments grappled to answer the high infant mortality rate. The neglected population was targeted to be served through NRHM and their tool was ASHA workers. Gradually, the figures suggest a substantial improvement in curtailing the infant mortality rate and maternity related deaths. Thus, the ASHA workers' contribution in health and hygiene has alleviated the worrying governments figures. Though, there is no elevation of ASHA workers themselves with respect to their employment status and they are continuous victims of government apathy.[9]

However, their intentional categorisation as 'volunteers' instead of regular employees restricts them from availing social security laws such as labour laws and its protection. This ambiguous status makes it easy for the government to bypass labour laws, leaving ASHAs open to exploitation and economic instability. It is deliberately built upon the façade of the term 'volunteers' so as to exclude them from the definition of workmen and to avoid the protective arm of the Contract Labour (Regulation and Abolition) Act, 1970. The Contract Labour Act, 1970 was enacted to extend protection to those workers who are employed on a contractual basis and working in specified industries. One of the general aspects of the type of work to be kept out of contractual labour is work which is perennial in nature. Is primary health care and services to women and children not perennial in nature? Are the primary health services to women and children not socially or politically (from the viewpoint of being a developed nation) important enough to be protected by the provisions of the aforesaid Act? Will the lowered infant mortality rate not contribute to the developing economy like India? Questions of this description are most important to take up the issue of extending labour law protection to ASHA workers.

Annual ASHA Update 2020-21[10], published by the National Health Systems Resource Centre (NHSRC), presents an in-depth analysis of the status, achievements, and challenges that the Accredited Social Health Activist (ASHA) programme has faced in the fiscal year 2020-21. This has created a mammoth community health volunteer program, where there are 9.83 lakh ASHAs deployed across 35 States and Union Territories. In fact, it is the largest such program globally, significantly impacting healthcare delivery at the grassroots level. ASHAs play an important role in Reproductive, Maternal, New born, Child, and Adolescent Health (RMNCHA), communicable diseases, and emerging challenges like non-communicable diseases (NCDs). The report shows that the ASHA training has been going very well. The completion rate for Round 1 is 96%, for Round 2 it is 92%, for Round 3 it is 89%, and for Round 4 it is 83%. But the training in specialised areas such as NCDs and HBYC lags at 55% and 60%, respectively, showing the need for accelerated efforts in these emerging health domains. Notably, these tireless workers' contributions during the recent pandemic have been commendable. They are credited with community surveillance for isolating the affected local pockets of the rural areas, generating awareness about the COVID 19 virus and best practices against its spread. During those desperate times ASHA workers were most effective in coordinating and supplementing local level institutions like Village Health and Sanitation Committees (VHSC) and Mahila Arogya Samitis (MAS) in different states of India.[11] Regardless of these invaluable contributions there are government data suggesting lack of regular training; absence of upskilling; delays in incentive payments; which can be discouraging for any worker much less ASHA worker.

Inadequate Compensation and Informal Status

The incentive-based work is good in the work environment where minimum pay matrix is assured. The moment we say minimum pay the precondition of regularised employment comes to mind. Regularisation under the labour laws is guaranteed to those who continuously work for a minimum number of days prescribed by the statute. The right to life with human dignity never envisaged obliteration of economic security. The situation becomes grave due to the reality of status that ASHA workers are immutably vexed with. The status of unorganised task based incentives instead of minimum fixed salary.

The said task based incentives are dependent on varied factors like accompanying a pregnant woman to the nearest health centre for immunisation. This does not consider ancillary work and preparation such as keeping a tap on the pregnancy duration and the due vaccination. Furthermore, the payment mostly is way less than statutory minimum wages without any respite in the amount of diligence and effort.[12] This draws a sorry picture of gross violations of some important constitutional and fundamental rights, relating to equal pay for equal work. It is admitted fact that even the task-based incentives of ASHA workers are way less than what is being paid to their male counterparts working in formal sectors for their task based incentives.

In the said circumstances the only equitable solution can be their regularisation with determined pay commensurate to minimum wages along with task based incentives for at least bridging the gap in pay. The statutory economic benefits of statutory deductions for insurance and pension should also apply in their employment conditions.

ASHA WORKERS AND LABOUR LAW IN INDIA: OLD AND NEW PERSPECTIVES

The role of ASHAs is critical in the public health system of India, especially in the rural areas, where healthcare infrastructure is usually very underdeveloped. Yet, despite their indispensable contributions, the ASHAs have been persistently excluded from formal labour protections, indicating massive gaps in the labour law framework of India, both historically and in its modern incarnation.

Old Perspectives: Exclusion from Formal Labour Laws

Traditionally, the Indian labour law system was designed with formal employees in regular, salaried jobs with specific rights and protections. ASHAs, being volunteers or honorary workers, were not included in this traditional framework. Their role as community health workers was not considered 'paid employment', and they were excluded from minimum wage laws and the protections offered by social security frameworks.

Under the Minimum Wages Act, 1948, Factories Act, 1948, and other similar legislation, the focus had been on the formal workers in industries and organised sectors. The laws provided minimum wages, hours of work, health insurance, and pensions that were unavailable to ASHAs, despite their critical work in maternal and child health, immunisation drives, and community health education.

This was largely on account of the fact that they were 'volunteers' rather than government employees. ASHAs were paid task-based incentives and not salaries. The reliance on an incentive-based system wherein the compensation depends on the performance of specific tasks has exposed ASHAs to late payment and, above all, insufficient income, which, despite working for long hours, is no easy job. This system is highly embedded in India's labour policy because informal labour is extensively used, especially in rural areas.

New Perspectives: Modern Labour Laws and the Case for Reclassification

Labour reforms in the recent past have tried to address some of these issues, although ASHAs are largely kept out of the purview of formal labour protection. The Code on Wages, 2019, and the Social Security Code, 2020 made some changes for the betterment of workers' conditions. It has consolidated existing laws and attempted to extend minimum wage guarantees to a wider range of workers, leaving ASHAs out because of their classification as volunteers. In the same manner, the Social Security Code promised to extend health insurance and pensions to workers in the gig economy and unorganised sectors but left out the special case of ASHAs as well.

Feminist critiques against the labour law point out the fact that significant care work in the hands of women, especially the work provided by ASHAs, goes unvalued and is unrewarded even in legal contexts. ASHAs, essential to public health initiatives, were still treated more or less like temporary or part-time workers at best, in a reflection of gender biases in labour law that continue to undervalue care work.

The Supreme Court of India's judgment in the case of State of Karnataka v Uma Devi[13] is quite relevant in the context of the employment status of ASHA workers and their labour rights. In this landmark case, the Court dealt with the issue of regularising the services of contractual employees in government departments, specifically reiterating that such regularisation would be permissible only under exceptional circumstances and in the absence of appropriate statutory or policy provisions. The relevance of Uma Devi in ASHA workers goes with the fact that it relates to the legal distinction between contractual and permanent employees. ASHAs, brought under the category of 'honorary volunteers' and compensated on a task-based incentive system fall in the same class of worker as without permanent employment status. The Uma Devi judgment would suggest that, unless a legal provision is made to regularise such workers, they cannot claim permanent employment benefits, irrespective of the nature of their work.

The judgment again emphasises the requirement of following proper procedures for recruitment into public sector jobs. This part of Uma Devi reminds us that although ASHAs have a very significant role in public health delivery services in India, their informal nature of employment will not be allowed to avail all the rights and protections provided under the government for its employees.

In the case of Maniben Maganbhai Bhariya v District Development Officer, Dahod[14], the Supreme Court, while referring State of Karnataka and v Ameerbi[15], ruled that Anganwadi workers (AWWs) and helpers (AWHs) are entitled to gratuity under the Payment of Gratuity Act, 1972. The Court observed that the term 'wages', as defined in the Act, has a broad scope, encompassing all emoluments earned by an employee while on duty. Also, the court ruled that the Anganwadi centers run by the State squarely fall under the definition of 'establishment' under the labour law. Consequently, the honorarium received by AWWs and AWHs falls within the ambit of this definition, making them eligible for gratuity. It rather underlines the legal and constitutional hurdles for making the employment of ASHAs more regular. It throws into sharp relief the dichotomy between the recognition of their essential contributions to public health and their exclusion from labour protections because of their informal, non-permanent employment status. Thus, where Uma Devi reinforces the legal barriers to regularisation, the Maniben Maganbhai Bhariya highlights the urgent requirement for legislative reform to secure workers' rights on ASHA work and ensure better recognition and compensations to bring parity with similarly placed Aanganwadi Workers.

The Need for Comprehensive Reform

This inbuilt systemic mischief needs to be rectified by re-categorising ASHAs as full-time employees in parity with other similarly placed health workers. Consequently, entitling them to fixed wages, social security benefits, and all other protections available

under the Minimum Wages Act, the Industrial Disputes Act, and other labour laws. They will also get adequate compensation for their work, an essential issue today because most ASHAs remain financially precarious.

More importantly, such labour reforms have to be complimented with incorporating gender-sensitive policies to ensure equitable valuation and remuneration for care work. In doing so, the gap between formal employees and informal workers is bridged. ASHAs' living and working conditions can improve, and their inclusion will bolster India's health care system as well.

The Courts in India have at times ruled, about the round the clock availability of ASHA workers or community health workers at the grass root (panchayat) level to ensure the right to maternity health qua expecting mothers so as to ensure that the issue of maternal mortality even in remote areas is addressed effectively, ensuring the effective implementation of NHRM.[16] This inherently portrays the indispensable nature of ASHA workforce deep within the remote parts of India with realising the vision of health to the last (wo)man standing. This is in consonance with the philosophy of Antyodaya[17] by the means of Sarvodaya,[18] which the State has to ensure, by implementing the welfare schemes for the poor and marginalised one's, concomitantly being mindful of the fact that such implementation does not infringe upon the rights of the people employed/entrusted for implementation of the same. It is high time to think that who is going to think for that woman who stands like a solid support beside the last woman for her to ensure upliftment.

The latest Supreme Court suggestion to induct ASHA and Anganwadi workers as Protection Assistants under the Domestic Violence Act, 2005 while making their critical role supporting vulnerable women in the rural areas is reflected.[19] This recommendation directly falls under the legal principle of 'equal pay for equal work' as established by several landmark judgments. In Mackinnon Mackenzie[20], the Supreme Court ruled that equal remuneration applies not only to jobs of identical value but also to work of equal value. This principle supports the claim that ASHA workers, despite their different roles, contribute equally to public health, similar to their government-employed counterparts.

The State of Madhya Pradesh v Pramod Bhartiya[21] case further consolidated that equal pay for equal work is a part of the equality doctrine under article 14 and also resonates with the directive principles of article 39(d). However, in Union of India v Indian Navy Civilian Design Officers Association[22], the Court reiterated that it is the executive's duty to decide the pay scales, and this decision seems to reflect judicial unwillingness to address pay inequality for non-governmental workers, though engaged and employed in the public sector or performing functions which are quintessential to effective functioning of the public system.

Despite the acknowledgment of the crucial work done by ASHA workers, they continue to suffer from unequal pay. The suggestion made by the Supreme Court, recently, though indirect, suggests gender justice and fair compensation for them. So far, though the judiciary is not successful in enforcing equal pay for such workers, it's now the turn of the legislature to define 'same work/work of equal value' clearly so that the pay and gender disparities may be redressed. This would uphold constitutional values and at the same time ensure that workers like ASHA workers are adequately compensated for their indispensable work.

In fact, even at the state specific legislation levels, say Rajasthan Platform-Based Gig Workers (Registration and Welfare) Act, 2023[23] or the Karnataka Platform based Gig Workers (Social Security and Welfare) Bill, 2024[24] are landmark pieces of legislation (passed and proposed) addressing vulnerabilities of the gig and platform workers in India. These acts provide a structure or framework for the registration, welfare, and protection of gig workers while setting a precedent for the inclusion of informal labour into formal systems. Therefore, ASHAs, who bridge the care and gig economies without the explicit coverage of these legislations, receive important impacts from such provisions.

Both acts show consideration for the special problems faced by gig workers, such as erratic earnings and missing social security and benefits of formal employment. While the law passed by Rajasthan require there to be a Gig Workers Welfare Board[25] charged with managing a social security fund that runs health insurance, pension schemes, and accident and sickness cover, Karnataka's proposed law aims at building a welfare fund that aggregates its funds from contribution made by the aggregator and the state government.[26] These laws recognise the need for collective bargaining rights, grievance mechanisms, and transparency in algorithmic management; these are all significant steps toward reducing the precarity associated with gig work.

For the ASHAs, such acts provide a comparative framework to understand how informal workers can be integrated into the formal welfare system. Although, the ASHAs are constituted as 'volunteers' under the NRHM, their task-based incentive model goes similar to that of the gig economy pay per task. Such acts of gig workers point in the direction where social security may be extended and adapted beyond formal employment to include the care economy.

Algorithmic accountability is another requirement, by which the Rajasthan and Karnataka laws (passed and proposed) make sure that fair work and compensation have been taken care of. Thus, this is particularly necessary where digital tools and mobile apps are used to monitor the work in any of those regions. Without regulation, algorithmic control in public health could further cement exploitation. Lessons learned from these Acts point to the need for similar controls within the ASHA program that would ensure fair work distribution and timely payment.

However, the acts also reveal the gaps in the labour law frameworks of India. While they have addressed the issues of gig economy workers, they leave out care workers like ASHAs who are integral to social welfare but not formally recognised. This omission again points to systemic undervaluation of care work and the need for a holistic policy that bridges the care and gig economies. Expanding the scope of these acts or introducing analogous legislation for care workers would give ASHAs the social protection they need urgently.

Therefore, these passed and proposed in the states of Rajasthan and Karnataka respectively, present a critical landmark within India's policy framework towards recognising informal labour. Principles underlying the two laws - such as social security, algorithmic accountability, and grievance redressal mechanisms-provide essential insights into overcoming the systemic neglect faced by ASHAs. Such a framework could therefore ensure equity, stability, and justice for the frontline health workers in India while strengthening constitutional commitments toward dignity and social welfare.

Grassroots Advocacy and Protests

In the past, ASHAs have protested and rallied to demand formal employment status, minimum wages, and social security.[27] A prime example is the rally held at Jantar Mantar in December 2024, where thousands of ASHA workers from across the country demanded a minimum wage of ₹26,000 per month, regularisation of their employment, and comprehensive social security.[28] The rally threw light on the callous attitude of the state towards their grievances and the dire need for systemic changes.

These movements have foregrounded the grievances of ASHAs but realised only incremental success. For example, some of the state government has increased their incentives or given honorarium announcements, which fall short of trying to address issues structurally regarding their marginalisation.

THROUGH THE LENS OF INTERNATIONAL HUMAN RIGHTS LAW

The plight of the ASHA workers in India can be analysed from the perspective of International Human Rights Law, with special reference to the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). All of these international instruments clearly underline the right to dignity, equality, and social security, grossly violated in the case of ASHA workers who are mostly women.

The ICCPR, article 6 thereof specifically, states the right to life with dignity. Such rights are denied because of their task-based and often delayed inadequate remuneration as economic exploitation, and their resultant financial insecurity also violates such a right of the ASHAs since their living condition is far from dignity. Furthermore, article 26 of the ICCPR guarantees the prohibition of discrimination on some specified grounds and equal protection of laws, which extends to the denial of basic rights and fair compensation for work, thus supporting the case for ASHAs' demand for recognition and fair wages. The said position was highlighted in the Zwaan-de Vries v Netherlands (1984)[29], by the Human Rights Committee, to list a few.

The ICESCR, in articles 6 and 7, guarantees the right to work and fair wages, as well as the right to just and favourable conditions of work, including social security. ASHA workers, who are excluded from labour laws and social security frameworks, face violations of these rights.

The task-based incentive system, coupled with irregular payments, undermines their ability to enjoy a decent standard of living. The lack of pensions, maternity benefits, and health insurance exacerbates their vulnerability, contradicting India's international obligations under the ICESCR to provide such protections to all workers, including those in the informal sector.

CEDAW, therefore, extends the provisions of equality by further advocating for the rights of women workers in employment from being discriminated against and for equal pay for equal work. Women constitute the majority of the workers from the ASHA scheme. This means that the lack of value attached to their work and remunerations is systemic discrimination. The undervaluation of care work, which is gendered by nature, directly violates the provisions of CEDAW about equal opportunities, wages, and social protections for women in all sectors or care economies. In this regard, India's failure to provide ASHA workers with adequate wages, social security, and formal employee status entails a direct breach of its international human rights obligations and a direct violation of Vishaka v State of Rajasthan[30] which interpreted the guarantee of gender equality, right to work with human dignity in articles 14, 15, 19(1)(g) and 21 of the Constitution.

It not only reflects a gender inequality but also contributes to the broader systemic issues in labour and social justice. The gaps need to be addressed. India must ensure that its ASHA workers are given formal employment status, fair remuneration, and access to social security benefits consistent with the principles under the ICCPR, ICESCR, and CEDAW.

GLOBAL COMPARISONS AND BEST PRACTICES WITHIN BRICS

Community Health Workers (CHWs) are becoming increasingly integral components of the formal labour force within many countries. For example, in Brazil's Family Health Program, CHWs are absorbed into the public health work force through the provision of some training, set wages, and benefits. It supports primary health care delivery while also making them secure so they can maintain attention on the much-needed services.[31]

Similarly, South Africa has institutionalised CHW roles through fixed contracts and comprehensive social security coverage. Workers are entitled to health insurance and pensions, fostering economic security and creating a sustainable healthcare workforce. In South Africa, CHWs receive fixed salaries and social security benefits, promoting economic stability and incentivising quality care.[32] This formalisation makes a strong point of the need to treat CHWs as vital contributors to public health and not informal workers, which could be adapted for ASHAs in India.

Russia's healthcare system presents a paradoxical situation of high physician-population ratios (4.2 per 1,000) alongside

significant physician shortages, particularly in primary care. This structural imbalance is exacerbated by weak primary care delivery, excessive specialisation, and hospital-centered service orientation.[33] Within this context, feldshers—mid-level practitioners positioned between nurses and physicians—play a crucial role in addressing healthcare delivery gaps, especially in rural and remote areas.

Feldshers emerged in imperial Russia and expanded during the Soviet period under the Semashko healthcare system, becoming institutionalised through feldsher-midwifery points (FAPs - feldshersko-akusherskie punkty) in rural settlements. With three to four years of specialised training, they provide basic diagnosis, treatment, preventive care, and emergency services where physicians are unavailable. This healthcare cadre serves as the first point of contact in villages with populations under 1,000, forming the most peripheral level of the Russian healthcare system.[34]

Despite government efforts to address physician shortages through the 'Providing medical organisations with qualified personnel' program (2018-2024)[35], structural reforms remain insufficient. The primary care sector continues to struggle, with district physicians managing only simple cases and referring approximately half of patients to specialists. General practitioners constitute only 12.8% of district physicians, with this percentage declining.[36]

The feldsher workforce faces challenges including aging personnel, inadequate compensation, limited career advancement, and insufficient modernisation. Many FAPs operate with poor infrastructure and outdated equipment, while the number of feldshers has declined in post-Soviet Russia, worsening rural healthcare access.

As Russia addresses its physician shortages, feldshers represent both a historical solution and a potential resource for expanding healthcare access. Their integration into comprehensive workforce planning could help mitigate primary care deficiencies and rural healthcare disparities. However, this requires modernising the feldsher role alongside structural reforms that strengthen primary care delivery and reduce excessive specialisation throughout the healthcare system.

Country	**First Responder CHW Model**	**Employment Status**	**Compensation & Benefits**	**Integration with Healthcare System**
Brazil (Family Health Workers)	Home visits, chronic disease management, maternal and child care	Formal employees	Fixed salary, pensions, social security, paid leave	Fully integrated into primary healthcare teams
Russia (formerly Feldshers)	Emergency medical aid, rural primary healthcare, referrals	Formal employees (during the soviet era)	Salaries, pension schemes	Embedded in rural health centers as paramedics
India (ASHAs)	Maternal health, immunisation, COVID-19 response, first aid	Volunteers	Task-based incentives, no fixed salary	Limited integration with formal health workforce
China (formerly Barefoot Doctors)	Primary healthcare, disease prevention, emergency care	Semi-formal	Fixed salary, training, social benefits	Part of state-run rural health workforce
South Africa (CHWs)	HIV/AIDS care, tuberculosis management, community health education	Formal contracts	Fixed wages, health insurance, retirement benefits	Integrated into government health facilities

The Barefoot Doctor system[37] and modern Community Health Worker (CHW) programs of China[38] both aim to improve healthcare accessibility in underserved areas, but they differ in structure, training, and implementation. The Barefoot Doctor initiative, introduced in China during the 1960s, trained rural farmers to provide basic medical services, focusing on preventive care, vaccinations, sanitation, and maternal health. They received short-term, informal training in both Western and traditional Chinese medicine, allowing them to serve as the primary healthcare providers in remote regions. Their role was deeply integrated into the collective farming system, and their services were either free or highly subsidised by the government. However, with the privatisation of China's healthcare system in the 1980s, the program was gradually phased out, leaving gaps in rural medical care.

In contrast, modern CHW programs operate globally, offering a more structured and specialised approach. Community health workers today receive formal training and certification, ensuring standardised healthcare delivery. Unlike barefoot doctors, CHWs often work under government or NGO-supported initiatives, receiving stipends or salaries. Their responsibilities have expanded beyond basic medical care to include chronic disease management, mental health support, and disease prevention programs. CHWs play a vital role in developing countries, particularly in regions with limited access to professional healthcare facilities. For instance, India's Accredited Social Health Activists (ASHAs) and Ethiopia's Health Extension Workers[39] serve as critical links between rural communities and formal healthcare systems, improving maternal health, immunisation rates, and disease control efforts.

One of the most significant international models is China's barefoot doctor program, which was developed during the Cultural

Revolution as a solution to rural shortages in healthcare. Barefoot doctors were trained for three to six months in maternal health, prevention of infectious diseases, and primary healthcare. They were gradually incorporated into the formal healthcare system, receiving formal training, payment, and social security benefits. This shift made rural healthcare sustainable while enhancing overall health outcomes. In comparison, India's ASHA workers continue to be informal volunteers who are rewarded only with task-specific incentives, with no financial security and full training.

In addition, contemporary variants of the barefoot doctor model provide a window into the future of CHWs in India. Experts such as Chi-Man Yip[40] suggest a '21st-century barefoot doctor', using AI-enabled diagnostic equipment and digital health platforms to improve efficiency. This strategy will resonate with India's requirement of equipping ASHAs with technology-based training and equipment so that they can deliver first-line healthcare services in excess of referrals. The integration of telemedicine and AI-based diagnostics can improve their efficiency, especially in rural and resource-scarce environments.

The achievement of barefoot doctors proves that models of health in communities are optimal when CHWs are provided with formal training, equitable pay, and institutional support. Through adopting best practices on a global level, especially from China, India can move ASHAs towards a formalised, technologically enabled cadre, ensuring their long-term contribution to public health as well as remediating systemic inequities in their job and compensation.

Rwanda[41] uses a performance-based financing system, which pays CHWs according to the results of their health service delivery. However, it complements this with fixed payments, continuous training, and capacity building. The hybrid system, therefore, keeps CHWs motivated by incentives, as well as a stable income and professional growth opportunities, making the sustainability of health programs much stronger.

India can take inspiration from such models if it reclassifies ASHAs as employees under existing labour laws, namely the Code on Wages, 2019, Industrial Relations Code, 2020, Code on Social Security, 2020, and Occupational Safety, Health and Working Conditions Code, 2020 before bringing them into force. This would bring in increased allocations to the health sector but through long-term benefits realised in the forms of better health outcomes for the people and lower rates of attrition of the workers. These are international best practices that provide working frameworks for India's ASHA scheme. This step will also align with India's commitment towards International Labour Organisation and BRICS declarations.

EPILOGUE

ASHAs are an integral but underappreciated force in India's healthcare system, functioning at the cusp of the care and gig economies. They are a lifeline in maternal and child health, immunisations, and health awareness. They are labelled as 'volunteers', thus they are excluded from formal labour rights. This further perpetuates economic exploitation and gender inequality in contravention of Articles 14, 21, and 39(d) of the Constitution.

International frameworks such as ICCPR, ICESCR, and CEDAW mandate fair wages, social security, and equal opportunities, but India's policies fall short, leaving ASHAs without minimum wages, pensions, or healthcare benefits. Countries like Brazil and South Africa provide successful models of integrating community health workers into formal labour systems with fixed salaries and social security.

These inequalities need to be rectified by making the ASHAs formal employees and providing them with social security and bringing in gender-sensitive reforms. Only then can it create a sound and equitable healthcare system.

The vital contributions of community health workers (CHWs) in world healthcare systems, as evidenced by ASHA workers in India, feldshers in Russia, barefoot doctors in China, and health extension workers in Ethiopia, emphasise the importance of grassroots delivery of healthcare. These workers serve as essential brokers between formal healthcare systems and hard-to-reach populations, offering necessary medical care, disease prevention interventions, and maternal and child health. In spite of their critical contributions, CHWs encounter systemic issues such as poor compensation, absence of formal recognition, and gender-based inequalities in working conditions.

ASHAs, as part of India's public healthcare system, have borne the additional burden, especially during the COVID-19 pandemic. They were among the frontline workers during pandemic response efforts, undertaking health surveillance, maternal and child health services, and spreading health awareness campaigns. But their efforts go unrecognised, with poor and infrequent remuneration, lack of job security, and minimal legal protection. The same trends are seen across other nations where CHWs function, indicating an international crisis in community healthcare provision.

In Russia, feldshers have long served as the backbone of rural healthcare, providing primary and emergency medical services. However, they face workforce shortages, geographical disparities in healthcare access, and policy inefficiencies that undermine their effectiveness. Despite government incentives to attract healthcare professionals to rural areas, feldshers continue to struggle with resource limitations and professional constraints. The barefoot doctor model in China is an important historical example, where community healthcare workers supported by the state were instrumental in rural health transformation. Yet the ultimate collapse of the barefoot doctor system owing to institutional under-prioritisation is a lesson in itself for other countries, including India, about the dangers of not formalising CHW positions.

The Ethiopian health extension program is a success story, as it shows how formal training, government backing, and integration into the formal health system can maximise the impact of community health workers. Ethiopia's model shows that investing in

education, training, and institutionalisation of CHWs can bring significant gains in public health outcomes. Rwanda's community health worker system also shows the significance of strategic health workforce planning, where properly coordinated policies have enhanced universal healthcare coverage.

One central challenge for CHWs in various contexts is the gender imbalance among the health workforce. As noted by the World Health Organisation, women comprise the majority of the community health workforce but are excluded from leadership positions, fair compensation, and decision-making authority. The ASHA worker model illustrates this challenge, where women do vast amounts of unpaid or underpaid work, mirroring wider systemic bias in global health institutions. The Friedrich-Ebert-Stiftung report underscores that closing the gender gap in healthcare employment calls for institutional legitimacy, equitable remuneration policies, and extensive protection of labour.

Policy interventions to improve CHWs need to tackle these entrenched problems by taking a multi-faceted approach. First, CHWs need to be institutionally recognised as core healthcare providers so they are included within national healthcare workforce policy. Second, remuneration systems should be restructured to offer adequate salaries and timely remittances, recognising the heavy work that CHWs undertake. Third, training programs need to be upgraded to prepare CHWs with the latest medical skills and knowledge to continue being effective. Fourth, legal safeguards must be established to ensure job security, social security entitlements, and protection against occupational risks.

Lessons drawn from global models indicate that strong institutional backing and government-supported policies are essential in maintaining and increasing community healthcare programs. In India, the institutionalisation of ASHA workers as full-time health workers, paid according to their workload, would go a long way in enhancing healthcare outcomes and worker satisfaction. Likewise, extending the function of CHWs in Russia, with improved incentives and inclusion in primary healthcare systems, would help deal with current shortages of the workforce. The achievements of Rwanda and Ethiopia drive home the value of strategic planning and investment in CHW programs.

In summary, international debate regarding CHWs, specifically ASHA workers, feldshers, barefoot doctors, and health extension workers, brings to the fore both their irreplaceable role and systemic impediments they encounter. Recognising, formalising, and compensating CHWs adequately is not just an issue of social justice but is also an indispensable step toward achieving universal health coverage. Through embracing best practices across various healthcare models globally, policymakers can provide support and recognition for CHWs to ultimately build strong healthcare systems and enhance health outcomes worldwide.

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